DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 09/29/2017 FORM APPROVED OMB NO. 0938-0397	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
	445419			vg		ි 09/27/2011		
NAME OF PROVIDER OR SUPPLIER				344444000000000000000000000000000000000	EET ADDRESS, CITY, STATE, ZIP COD	E		
OVERTON COUNTY NURSING HOME				LIVINGSTON, TN 38570				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	ON SHOULD BE COMPLETION DATE		
F 000	INITIAL COMMEN	тѕ	FC	000				
	conducted on Sept County Nursing Ho in relation to the co	nvestigation of#TN00028467 ember 27, 2011, at Overton me, no deficiencies were cited implaint under 42 CFR PART ents for Long Term Care.						
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				111111111111111111111111111111111111111				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.